Composite Report
On
The Ten Key Components
In Selected Missouri Drug Court Programs

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Ten Key Components Report
Missouri Drug Courts

NOTE: A checked box indicates consistent compliance across courts.

Key Component #1: Drug courts integrate alcohol and other drug treatment services with justice system case processing

Performance Benchmarks:

1. Initial and ongoing planning is carried out by a broad-based group, including persons representing all aspects of the criminal justice system, the local treatment delivery system, funding agencies, the local community other key policy makers.

   Several models were employed in initiating the fourteen drug courts in this study, ranging from those in which a formal planning structure of policy makers was convened to a more common approach in which a small group of practitioners provided the impetus. Most of the fourteen drug courts studied were not developed in the all-inclusive manner that this benchmark envisions. With several notable exceptions, drug courts were developed by "in-house" teams, usually at the instigation of some charasmatic leader who took the initiative. In over half of the jurisdictions that individual was a sitting judge who saw this approach as a viable solution to a difficult and growing problem. The next most common initiator was a prosecuting attorney. The usual process was for a case manager representative such as probation/parole or juvenile officer and a treatment provider to be contacted by the initiator. In about one-half of the courts, probation and parole was a primary early player. The role of defense counsel is a mixture running from active and early participation in shaping the structure of the court to active opposition. Law enforcement may have been informed but in only one instance does it appear that this segment of the criminal justice system was a party to the planning process. Elected officials outside the judiciary and other policy shapers were not included in the initial planning team in any of the fourteen courts.

2. Documents defining the drug court's mission, goals, eligibility criteria, operating procedures, and performance measures are collaboratively developed, reviewed, and agreed upon.

   Eight of the courts have a formal statement of mission, goals criteria, etc. The process has been that one person from within the initial team took the initiative in developing this document and it was then agreed to (more or less) by the active treatment team which doubles as the policy board for most of the courts. The reliance on oral tradition is common and formal guidelines are treated as flexibile, even where officially promulgated. As the courts have grown and evolved, greater variance from written documents begins to appear in day-to-day practice. In only one court was there a formal periodic mechanism for review of written policy and guidelines.

3. Abstinence and law-abiding behavior are the goals, with specific and measurable criteria marking progress. Criteria may include compliance with program requirements, reductions in criminal behavior and AOD use, participation in treatment, restitution to the victim or to the community, and declining incidence or AOD use.

   All of the courts reviewed, irrrespective of their specific type, have adopted the goals noted in this benchmark and most have additional specific compliance requirements and expectations. Financial responsibility is heavily stressed as a criterion for graduation including payment of court ordered restitution and child support. All the adult courts have regular employment as a criterion but this is frequently waived based on the circumstances of the client. Both adult and juvenile courts have educational attainment (regular attendance and/or GED completion) as an emphasized component.

4. The court and treatment providers maintain ongoing communication, including frequent exchanges of timely and accurate information about the individual participant's overall program performance.

   Ten of the fourteen courts examined have weekly staffings by the drug court team; one meets bi-monthly and three meet once per month. These are the primary means of ongoing communication but not the only devices used. Phone contact, particularly between the treatment provider and case manager is frequent, often daily, even where the time between team meetings is more lengthy. Client non-compliance reporting is generally immediate and, if serious, communicated directly to the judge/commissioner.

5. The judge plays an active role in the treatment process, including frequently reviewing of treatment progress. The judge responds to each participant's positive efforts as well as to noncompliant behavior.

   Judges' roles vary considerably although most take an active role in the process. Eleven of the fourteen consider themselves to be part of the staffing team and participate in the discussion and analysis of client progress. The remaining three do not attend staffing but review summary reports and recommendations on individuals who are appearing before them. Four specifically vest decision authority in the staffing team using a democratic voting procedure. However, most judges reserve the final decision authority to themselves and modify staffing decisions in court as they see fit.

6. Interdisciplinary education is provided for every person involved in drug court operations to develop a shared understanding of values, goals, and operating procedures of both the treatment and justice system components.

   None of the courts studied has an on-going interdisciplinary training initiative in place although in most instances the core team went through some training during the early formation stages of the court. Current training, where it exists, consists of attending national and/or state conferences, sometimes as a group. Initially there seems to have been an emphasis in this area but it has dissapated somewhat as time has gone on. New members to the team do not routinely go through training as turnover occurs and this is an area of mounting concern as staff changes take place. Budget constraints are clearly evident in discussing training with the judges.

7. Mechanisms for sharing decision making and resolving conflicts among drug court team members, such as multidisciplinary committees, are established to ensure professional integrity.

   The most commonly employed formal structure is the staffing team which either resolves issues or makes recommendations to the judge/commissioner. There were a number of instances found in which substantial conflict was not really addressed and parties had withdrawn from active participation in drug court. Ultimate authority over policy seems to be a function of participation, i.e., veto power is exercised in a particular area or the party withdraws from participation. This has been particularly apparent in the role of public defenders.

Key Component #2: Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights

Performance Benchmarks:

1. Prosecutors and defense counsel participate in the design of screening, eligibility, and case-processing policies and procedures to guarantee that due process rights and public safety needs are served.

   The prosecuting attorney (or the person performing this function, e.g., juvenile office, legal counsel to DJO, etc.) is a key figure in all courts, usually the primary gatekeeper either in initiating referrals to drug court or in screening requests from other parties such as defense counsel, treatment providers or case managers. In almost half (6) of the courts, the public defender plays little or no role. Public defenders have chosen to withdraw or never participated in the first place because of conflict over the nature of the plea arrangement, i.e. diversion vs post-plea. There appears to be a substantial philosophical difference between many public defenders and judges over what elements are essential for effective intervention. The debate is couched in ideological rather than empirical positions and appears often to be impacted by pervailing community values as well.

2. For consistency and stability in the early stages of drug court operations, the judge, prosecutor, and court appointed defense counsel should be assigned to the drug court for a sufficient period of time to build a sense of teamwork and to reinforce a nonadversarial atmosphere.

   In all but one of the courts studied the judge has been with the drug court initiative since its inception and usually was the primary impetus to the program getting established in the first place. Continuity in the other roles is more mixed, particularly with public defenders and court appointed defense counsels. In courts where there has been a high degree of continuity the staffing team functions more smoothly and the roles of each of the participants are less narrowly defined. Familiarity has allowed for greater flexibility among the participants and the ease and unanimity of decision making is clearly evident.

3. The prosecuting attorney

   ☒ reviews the case and determines if the defendant is eligible for the drug court program;

   All of the benchmarks under this heading appear to be regularly and consistently met in the adult drug courts; practice in the juvenile and family courts varies widely on this issue.

   ☒ files all necessary legal documents;

   ☒ participates in a coordinated strategy for responding to positive drug tests and other instances of noncompliance;

   ☒ agrees that a positive drug test or open court admission of drug possession or use will not result in the filing of additional charges based on that admission;

   ☒ makes decisions regarding the participant's continued enrollment in the program based on performance in treatment rather than on legal aspects of the case, barring additional criminal behavior.

4. The defense counsel

☐ reviews the arrest warrant, affidavits, charging document, and other relevant information, and reviews all program documents (e.g., waivers, written agreements),

The response here is very mixed. In half of the courts reviewed public defenders/defense counsels take a clear and active role in both educating and advocating for their clients. In other situations, the responsibility of explaining rights, obligations and alternatives to drug court falls primarily to the court administrator and/or case manager. Even though this information is often presented in detailed written form, absent an active participation by defense counsel, clients maintain that they did not understand the nature of process into which they were entering or what alternatives might be available to them (such as straight probation).

☐ advises the defendant as to the nature and purpose of the drug court, the rules governing participation, the consequences of abiding or failing to abide by the rules, and how participating or not participating n the drug court will affect his or her interests;

see comments above

☐ explains all of the rights that the defendant will temporarily or permanently relinquish;

see comments above

☐ gives advice on alternative courses of action, including legal and treatment alternatives available outside the drug court program, and discusses with the defendant the long-term benefits of sobriety and a drug-free life;

see comments above

☐ explains that because criminal prosecution for admitting to a AOD use in open court will not be invoked, the defendant is encouraged to be truthful with the judge and with treatment staff, and informs the participant that he or she will be expected to speak directly to the judge, not through an attorney.

see comments above

Key Component #3: Eligible participants are identified early and promptly placed in the drug court program

Performance Benchmarks:

1. Eligibility screening is based on established written criteria. Criminal justice officials or others (e.g., pretrial services, probation, Treatment Approaches for Safer Communities(TASC)) are designated to screen cases and identify potential drug court participants.

   All but two of the fourteen courts have explicit written criteria. However there is some latitude in application of these criteria, particularly as the programs have expanded and widened the types of individuals being served. For instance, "non-violent" offenders is a universal criterion and yet the case records show a number of persons with prior assault arrests have been admitted. Admission of such clients appears to be an individually negotiated arrangement. Addiction screening is conducted by various entities including the case managers, drug court personnel and the contract treatment providers. Frequently more than one screening is done (initial by DC staff or Probation and Parole(P/P) officer and then, subsequent to referral, by the treatment agency). Standardized instruments are used at entry but their use as a followup tool has not been fully exploited.

2. Eligible participants for drug court are promptly advised about program requirements and the relative merits of participating.

   Once an actual referral has been made to drug court the process described in this benchmark seems to be normative in all courts. P/P performs this function with re-entry clients. In juvenile courts the parents as well as the child are involved in this step as a matter of policy.

3. Trained professionals screen drug court-eligible individuals for AOD problems and the relative merits of participating.

   All screeners have some degree of training in Alcohol and Other Drug (AOD) assessment and several courts use fully qualified mental health professionals who conduct a comprehensive bio-psycho-social study as well as the more abbreviated AOD screen.

4. Initial appearance before the drug court judge occurs immediately after arrest or apprehension to ensure program participation.

   Rarely does initial appearance in any of the courts studied occur "immediately" after arrest. The time lag between these two events is more usually measured in months rather than days. In a number of cases analyzed, years passed in continuences and plea bargaining processes before a referral to determine eligibility was made. However, once the actual referral takes place, the process of screening, acceptance/rejection and first appearance moves rapidly.

5. The court requires that eligible participants enroll in AOD treatment services immediately.

   In six of the courts the expectation is that the participant will begin a formal regime the following day. In two of the courts examined participants do not routinely go into AOD treatment within a week of first court appearance.

Key Component #4: Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services

Performance Benchmarks:

1. Individuals are initially screened and thereafter periodically assessed by both court and treatment personnel to ensure that treatment services and individuals are suitably matched

   ☐ An assessment at treatment entry, while useful as a baseline, provides a time specific "snapshot" of a person's needs and may be based on limited or unreliable information. Ongoing assessment is necessary to monitor progress, to change the treatment plan as necessary, and to identify relapse cues.

   Formal assessment at entry is standard practice in all courts. Thereafter assessments are more informal consisting of brief progress and compliance reports from case managers and treatment providers. These take place orally in team staffings and one-third of the courts maintain some written record of these comments in brief form if there are no apparent problems and in greater detail if the client's behavior appears to be problematic. More detailed casenotes are maintained by P/P and the treatment providers than those available in drug court records.

   ☐ If various levels of treatment are available, participants are matched to programs according to their specific needs. Guidelines for placement at various levels should be developed.

   All of the courts use "levels" systems in which behavior is matched to intensity/frequency of both treatment and surveillance contacts.

   ☐ Screening for infectious diseases and health referrals occurs at an early stage

   Most of the courts use a self-reporting screening mechanism to identify "high risk" participants. Two regularly do physical screening as part of the normal intake process. There is little evidence that participants are referred for health issues with any degree of frequency. Formal relationships between health care and treatment providers are generally lacking.

2. Treatment services are comprehensive:

☒ Services should be available to meet the needs of each participant.

AOD treatment services are provided to all participants in all but one court. In that one, clients are expected to make such treatment arrangements for themselves. Meeting the "needs of each participant" beyond the substance abuse area is far less comprehensive. Referrals to other resources are used but the files evidence only sporadic activity of this nature.

☒ Treatment services may include, but are not limited to; group counseling; individual and family counseling; relapse prevention; 12-step self-help groups; preventative and primary medical care; general health education; medical detoxification; acupuncture for detoxification, for control of craving and to make more people amenable to treatment; domestic violence programs; batterers' treatment; and treatment for long-term effects of childhood physical and sexual abuse.

Group and individual counseling are provided in all programs; nine emphasize some form of a twelve-step model but a number of treatment providers are gradually moving away from this approach. General medical care is almost completely absent as a regular part of most programs and is outside the contract funding stream. Detoxification service is problematic in the rural areas and may require transportation to a larger trade center where it is available though a medical hospital. Only one court reported that domestic violence counseling was a regular part of its treatment and two noted a program specific to batterers to which they make referrals. A number did, however, note that counseling and education regarding abuse impact were incorporated into their regularly mandated group sessions.

☐ Specialized services should be considered for participants with co-occurring AOD problems and mental health disorders. Drug courts should establish linkages with mental health providers to furnish services (e.g., medication monitoring, acute care) for participants with co-occurring disorders. Flexibility (e.g., in duration of treatment phases) is essential in designing drug court services for participants with mental health problems.

It is relatively uncommon for the treatment providers in these courts to address co-occuring disorders even though the client profiles indicate that this is a common phenomenon. Treatment focus is primarily on addiction unless there is a pre-existing diagnosis and treatment history and then the pattern is to refer for psychiatric services. In a number of instances this causes problems because the court-contracted AOD provider has a prohibition against use of any chemical substances including standard psychotropic medications. Several courts have taken the initiative to intervene in this arena and mediate between the treatment providers on behalf of the clients.

☐ Treatment programs or program components are designed to address the particular treatment issues of women and other special populations.

Five of the fourteen have gender and/or population specific programming.

☐ Treatment is available in a number of settings, including detoxification, acute residential, day treatment, outpatient, and sober living residences.

Nine of the courts have in-patient services immediately available to them; the others go outside of the community to obtain resources on an as-need basis. Social detoxification is available in several. Medical detoxification is rare. Seven have some day treatment option.

☐ Clinical case management services are available to provide ongoing assessment of participant progress and needs, to coordinate referrals to services in addition to primary treatment, to provide structure and support for individuals who typically have difficulty using services even when they are available, and to ensure communication between the court and the various service providers.

Clinical case management services appear to be a shared function between Probation/Parole staff and treatment providers. In most courts the P/P staff carry major responsibility in this area although the drug court administrators also serve as a critical communication linkeage with the other members of the team.

3. Treatment services are accessible:

☐ Accommodations are made for persons with physical disabilities, for those not fluent in English, for those needing child care, and/or for persons with limited literacy.

Most of the treatment facilities are ADA compliant and where not, alternative arrangements have been instituted. Two of the providers offer child care services and four have specific programmatic provisions for clients with limited literacy. Second lanaguage competence has not yet become a major issue but at several sites with significant immigrant population it is a concern that will need to be addressed.

☐ Treatment facilities are accessible by public transportation, when possible.

Although a number of the courts are in rural areas where there is no public transportation, the client survey data do not indicate that this lack is problematic in accessing services. The one court where this was reported as an issue was in a metro area and had to do with congruence of transportation, treatment, and other schedules as much as availability of public transportation.

4. Funding for treatment is adequate, stable, and dedicated to the drug court;

☐ To ensure that services are immediately available throughout a participant's treatment, agreements are made between courts and treatment providers. These agreements are based on firm budgetary and service delivery commitments.

Funding is viewed as tenuous by personnel in nine of the fourteen courts studied. Resource allocations are on a year-to-year basis and dependent upon appropriation. Drug court funding is not a specific dedicated line-item in any budget that can be counted on even though it has enjoyed vigorous support, particularly from the highest levels of the judiciary. Evidence of the instability is that during the period of study, two courts lost their treatment providers when contracts were cancelled in payment rate disputes.

☐ Diverse treatment funding strategies are developed based on both government and private sources at national, State and local levels.

Creativity is the watch-word in the funding arena. The program demands are growing within the established courts in this study and new courts are rapidly developing to compete for the available funds. Efforts to enlarge the resource pool require going well beyond the traditional state and federal appropriations.

☐ Payment of fees, fines, and restitution is part of treatment.

Four of the courts have no fee requirements what-so-ever. Among the remaining ten the fee range is from $250.00 to $1455.00 for the entire program. All courts which require fees have some form of sliding scale and even a provision for fee waiver if recommended by the staffing team. Where fees and restitution are required, they are incorporated into the Drug Court protocol.

☐ Fee schedules are commensurate with an individual's ability to pay. However, no is turned away solely because of an inability to pay.

cf comments above

5. Treatment services have quality controls:

☐ Direct service providers are certified or licensed where required, or otherwise demonstrate proficiency according to accepted professional standards.

The majority met minimum standards established in law for AOD counseling programs and at least five of the courts have providers that well exceed those professional standards. Of the contract providers (the number exceeds fourteen because several courts have more than one) only one had credentials that were somewhat questionable.

☒ Education, training, and ongoing clinical supervision are provided to treatment staff.

All appear to meet minimum standards in this regard; almost half (6) demonstrate high levels of training and supervisory practice.

6. Treatment agencies are accountable:

☐ Treatment agencies give the court accurate and timely information about a participant's progress. Information exchange complies with the provisions of 42 CFR, Part 2 (the Federal regulations governing confidentiality of AOD abuse patient records) and applicable with State statutes.

Oral rather than formal written reports are the rule. Nine of the fourteen courts do not receive regular written progress reports from treatment providers. Evidence is clear that all appropriate confidentiality standards are being closely adhered to.

☐ Responses to progress and noncompliance are incorporated into the treatment protocols.

Monitoring of progress/non-compliance is a major focus of the staffing/treatment team in its periodic meetings and sanctions and/or rewards are jointly decided upon or recommended based on client performance. Generally the judges/commissioners are very direct in communicating the relationship between behavior and treatment adjustment to the clients in the open court setting, not only for the specific client's benefit but as pointed communication to the other drug court participants who are present.

7. Treatment designs and delivery systems are sensitive and relevant to issues of race, culture, religion, gender, age, ethnicity, and sexual orientation.

This varies widely from court to court; some courts make specific efforts to be culturally sensitive and others have treatment providers who employ a generic interventive protocol that is universally applied irrespective of the characteristics of the clientele being served.

Key Component #5: Abstinence is monitored by frequent alcohol and other drug testing

Performance Benchmarks:

1. AOD testing policies and procedures are based on established and tested guidelines, such as those established by the American Probation and Parole Association.

Where testing is conducted by Probation/Parole staff or specifically trained court personnel (9 courts), specific common guidelines are used. In those instances in which the courts must rely on the treatment provider to do the testing, there is less uniformity of testing protocol.

2. Testing may be administered randomly or at scheduled intervals, but occurs no less than twice a week during the first several months of an individual's enrollment. Frequency thereafter will vary depending on participant progress.

Seven of the courts begin clients with testing twice or more per week; ten of the fourteen are now using some form of random testing although most began with a scheduled testing model.

3. The scope of testing is sufficiently broad to detect the participant's primary drug of choice as well as other potential drugs of abuse, including alcohol.

The level and scope of testing is gradually becoming more sophisticated as the technology develops and the practitioners gain more experience and confidence with it. Currently drug screening is fairly comprehensive but alcohol monitering is still problematic in most jurisdictions.

4. The drug-testing procedure must be certain. Elements contributing to the reliability and validity of a urinalysis testing process include, but are not limited to,

Most of the courts have gone to in-house testing as the procedures have become easier to use and this now provides for immediate results rather than the delay that was characteristic in most courts early in their development. Several of the courts still routinely send positive results to an outside laboratory for verification while others do so only when the participant contests the results. The costs associated with testing and third party analysis of samples are becoming major issues for the drug court administrators.

☐ Direct observation of urine sample collection;
Gender considerations are the major deterrent to direct observation of samples. This is particularly problematic is rural areas with small staffs. A number of the well-qualified case managers are female and the drug court population is predominately male (six courts) and under these circumstances direct observation proceedures have been difficult to implement.

☐ Verification temperature and measurement of creatinine levels to determine the extent of water loading;

This varies widely from court to court and procedures are inconsistently applied. The technology generally employed requires that such verification and measurement be done with laboratory resources which many of the courts do not have readily available.

☐ Specific, detailed, written procedures regarding all aspects of urine sample collection, sample analysis, and result reporting;

Probation and Parole has specific, detailed written procedures in place and these provide a solid foundation for the courts to employ. Where the P/P officer acts as case manager (and barring the gender issue noted above) there appears to be good quality control of the sampling process.

☐ A documented chain of custody for each sample collected;

see comments above

☐ Quality Control and quality assurance procedures for ensuring the integrity of the process; and

see comments above

☐ Procedures for verifying accuracy when drug test results are contested.

see comments above; all of the courts examined provided specific procedures for participants to challenge testing results and great care appears to be taken that due process considerations are addressed in these situations.

5. Ideally, test results are available and communicated to the court and the participant within one day. The drug court functions best when it can respond immediately to noncompliance; the time between sample collection and availability of results should be short.

Eight of the courts meet the one day benchmark for communicating positive results to the court. Negative results are communicated at the next team meeting at which the participant is staffed. Two other courts have a 48 hour deadline and the remainder share results at the next regularly scheduled staffing team meeting. In the event that the case manager or court administrator considers the behavior to be potentially dangerous, communication of results can and is more immediate in these courts.

6. The court is immediately notified when a participant has tested positive, has failed to submit to AOD testing, has submitted the sample of another, or has adulterated a sample.

   Six of the fourteen courts indicate that reports of positives, missed, fraudulent and adulterated tests are submitted to the judge immediately. In the remainder this communication takes place at the next team meeting unless there are particularly egregious circumstances complicating the matter.

7. The coordinated strategy for responding to noncompliance includes prompt responses to positive tests, missed tests, and fraudulent tests.

   Two of the courts have standardized sanctions that are applied for non-compliance involving community service and jail terms. In the others a variety of sanctions, including those listed above, are used but the response is individualized to the particular client and most often is arrived at after discussion by the treatment team and the judger/commissioner. Substantial arguments are made on both sides of this issue, both for standardized and uniform sanctions impartially applied and for an individualized treatment approach and this debate has not been resolved in several of the courts studied.

8. Participants should be abstinent for a substantial period of time prior to program graduation.

   The term "substantial" is open to numerous operational definitions and the Missouri courts use a full range from no specifically set time (judicial discretion based on team recommendation) up to twelve months drug free (two courts). Five of the courts require six months of continuous abstinence, two demand eight months and the remaining two require the last ninety days to be clean. In some instances where use is minor and the participant has been in the program for an already extended period of time, the prescribed time will be waived. In other cases it appears that time alone is the controlling criterion.

Key Component #6: A coordinated strategy governs drug court responses to participants' compliance.

Performance Benchmarks:

1. Treatment providers, the judge, and other program staff maintain frequent, regular communication to provide timely reporting of progress and noncompliance and to enable the court to respond immediately. Procedures for reporting noncompliance re clearly defined in the court's operating documents.

   Only two of the courts have a regularized written procedure for reporting non-compliance but this does not appear to be problematic. The team meetings/staffings serve as a communication clearinghouse and the treatment providers, court coordinators and the case managers mainitain on-going contact, usually by phone. A substantial amount of discretion is vested in the staff to decide what is "serious" and needs to be brought to the court's attention immediately.

2. Responses to compliance and noncompliance are explained verbally and provided in writing to drug court participants before their orientation. Periodic reminders are given throughout the treatment process.

   Potential responses are explained verbally to the participants in all of the courts, frequently by several members of the team at various stages of the intake and screening process. In seven of the courts a detailed written statement is contained in the participant manual, handbook or contract signed at the start of the program.

3. The responses for compliance vary in intensity.

   ☒ Encouragement and praise from the bench;

   This is universally done and all participants, professionals and clients alike, describe this function as one of the most important, innovative and effective aspects of the drug court program.

   ☒ Ceremonies and tokens of progress, including advancement to the next treatment phase;

   Again, all of the courts surveyed used formal ceremonies as an intergel component of the program with a variety of "rite of passage" activities leading to a formal graduation ceremony. As resources and creativity permit, various tokens of achievement are employed by most of the courts.

☐ Reduced supervision;

Nine of the fourteen courts have specific plans for reduced supervision as a reward for consistent compliance.

☐ Decreased frequency of court appearances;

Twelve of the fourteen employ some form of appearance reduction as an incentive; those that do not, already have less regular court appearance requirements.

☐ Reduced fines or fees;

Only three of the fourteen reduce the required fees as a reward for compliance; no court reported that judicial levied fines were adjusted for behavior.

☐ Dismissal of criminal charges or reduction in the term of probation;

Ten courts offer probation reduction and/or dismissal of criminal charges as an incentive. Of the two alternatives in this benchmark, the former is more frequently used. The non- use of the latter is the source of contention with some of the state public defender offices as noted above.

☐ Reduced or suspended incarceration: and

Only four of the courts report that this is an incentive they use with any regularity

☐ Graduation.

As mentioned above, this is a universal aspect of all the programs and in a number of instances has become a quite elaborate involving family and dignitaries. In the past year at least three justices of the Supreme Court have traveled to courts to serve as graduation speakers.

4. Responses to or sanctions for noncompliance might include

☒ Warnings and admonishment from the bench in open phases;

In all courts, warnings and admonitions are given from the bench routinely, not only for the benefit of the client standing there but as part of the culture-setting that is core to the drug court process. Elements of both therapeutic community and positive peer culture approaches to behavioral change are evident in the performance of judges/commissioners before the assembled audience of drug court participants.

☒ Demotion to earlier program phase;

All but one of the programs have specific provisions for demotion to an earlier level of program as a condition of non-compliance; associated with this is the requirement that the client will take longer to complete the total program and will continue to remain under the stricture of supervision.

☒ Increased frequency of testing and court appearances;

Again, thirteen courts use increase in surveillance and treatment contact, particularly number of group sessions per week, as a sanction. Some treatment providers do have questions about the appropriateness of linking perceived punishment and treatment contact in the client's mind and how this impacts the recovery process. Most, however, link intensity with need as demonstrated by the client's lack of compliance.

☐ Confinement in the courtroom or jury box;

Rarely used, even in the four courts that list this as one of the sanctions employed.

☐ Increased monitoring and/or treatment intensity;

Twelve of the fourteen utilize this approach; please refer to the comments above re: treatment - punishment linkage.

☐ Fines;

Three of the courts reported the imposition of monetary fines as a consequence of noncompliant behavior.

☒ Required community service or work programs;

Community service is a strong component of most (12) of the courts. Additional required hours are a regularly imposed consequence, particularly for infractions such as missing scheduled case manager and/or treatment provider contacts.

☐ Escalating period of jail confinement (However, drug court participants remanded to jail should receive AOD treatment services while confined; and.

While escalating periods of jail/detention confinement are used in twelve of the jurisdictions, the issue raised in this benchmark about continuing treatment during such time is a concern. In many situations the treatment provider is not equipped to export a program to a county jail and critical components such as group therapy cannot be maintained. For this reason, judges are inclined to use short jail times unless the behavior is such that it appears termination from the program is imminent.

☒ Termination from the program and reinstatement of regular court processing.

All the courts retain this option and exercise it when noncompliance reaches the level where intervention seems to no longer have any positive prognosis and/or when the client's behavior has become clearly detrimental to the well-being of other program participants.

Key Component #7: Ongoing judicial interaction with each drug court participant is essential

Performance Benchmarks:

1. Regular status hearings are used to monitor participant performance:

☐ Frequent status hearings during the initial phases of each participant's program establish and reinforce the drug court's policies, and ensure effective supervision of each drug court participant. Frequent hearings also give the participant a sense of how he or she is doing in relation to others.

In eleven of the fourteen courts the clients begin the program with mandatory weekly appearances before the judge/commissioner and the frequency then lessens as they make progress in the program, usually to bi-monthly in phase II and monthly during the final stages in the program. In addition and particularly in those programs where court appearances are less regular, the case manager and court coordinator attempt to provide regular feedback between appearances both to offer positive encouragement and to remind the client that surveillance is taking place.

☐ Time between status hearings may be increased or decreased, based on compliance with treatment protocols and progress observed.

see comments above

☐ Having a significant number of drug court participants appear at a single session gives the judge the opportunity to educate both the offender at the bench and those waiting as to the benefits of program compliance and consequences for noncompliance;

Several of the courts specifically require that participants attend together and that everyone remain until all cases on that docket have been heard. Logistical considerations as well as judicial preference change this is other jurisdictions.

2. The court applies appropriate incentives and sanctions to match the participant's treatment progress

   Three of the courts have written standardized incentives and two have sanctions in this form. In all the others sanctions and incentives are an individualized format based on some combination of team and judge's decision. "Appropriateness" is tailored to the needs and performance of each client. This approach has significant positives to commend it but also runs the risk of appearing inconsistent and even biased.

3. Payment of fees, fines and/or restitution is part of the participant's treatment. The court supervises such payments and takes into account the participant's financial ability to fulfill these obligations. The court ensures that no one is denied participation in drug courts sole because of inability to pay fees, fines, or restitution.

   As noted in previous comments, fees are generally required and are adjusted to the client's ability to pay but there is a general expectation in most courts that the client will contribute to defraying the cost of treatment. Restitution is emphasized in three courts where the concepts of equity and personal responsibility are strongly incorporated into the entire treatment philosophy.

Key Component #8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness

Performance Benchmarks:

1. Management, monitoring, and evaluation processes begin with initial planning. As part of the comprehensive planning process, drug court leaders and senior managers should establish specific and measurable goals that define the parameters of data collection and information management. An evaluator can be an important member of the planning team.

   None of the circuits studied began with specific, measurable goals operationally defined to the extent that this benchmark envisions although some did, in their initial program proposal attempt to define quantifiable outcomes. All had generalized goals for the program and some initial expectation of client flow but none developed an evaluation protocol as part of the planning process and most had only rudimentary data and management information systems in place. As the programs have matured and increased in their sophistication, more attention is being paid to this area. Comparison data on drug court outcomes as contrasted with other forms of probation are increasingly being asked for by local policy makers and this is giving impetus to drug court coordinators in seeking more assistance in design of impact and outcome studies.

2. Data needed for program monitoring and management can be obtained from records maintained for day-to-day program operations, such as the numbers and general demographics of individuals screened for eligibility; the extent and nature of AOD problems among those assessed for possible participation in the program; and attendance records, progress reports, drug test results, and incidence of criminality among those accepted into the program.

   A common characteristic across all fourteen jurisdictions, irrespective of the type of court or the nature of the specific clientele being served, was that there is no central repository of data that can be accessed to obtain a full picture of a client's history and progress in this program. Several of the courts are now taking steps toward centralization of information but the prevailing model remains that each of the team participants and their respective organizations maintain files specific to their specialization within the process and critical information is communicated often in a very informal manner.

3. Monitoring and management data are assembled in useful formats for regular review by program leaders and mangers.

   Several of the courts are working toward MIS systems which, if fully implemented, can provide continuous information feedback for court administrators for use in program and funding processes. At the present time none of the courts surveyed had a system in place that was sufficient to these purposes. This was not because it was seen as unimportant but because of a lack of resources (time, expertise and money) to develop this aspect of the management function. It was universally agreed by the court representatives that a standardized structure needs to be developed and some party external to the individual courts should take the initiative in that regard.

4. Ideally, much of the information needed for monitoring and evaluation is gathered through an automated system that can provide timely and useful reports.

   Three of the courts have abbreviated forms of the "Buffalo" system that partially address the management needs. Nine of the courts have no automated data process what-so-ever. One court is working on a pilot project with Washington University to field test an automated system that offers the promise of real-time feedback on critical client, program and fiscal data.

5. Automated and manual information systems adhere to written guidelines that protect against unauthorized disclosure of sensitive personal information about individuals.

   This benchmark appears to be met by all of the courts studied. The Probation/Parole standards for safeguarding data are generally employed and they are quite comprehensive. One issue that does arise in this area is communication between certain treatment providers and the treatment team where the provider asserts absolute confidentiality of content in counseling sessions. This tends to truncate the team process and becomes a power and control issue that is divisive.

   ☐ The drug court program ensures that the evaluator has access to relevant justice system and treatment information.

   To date in this process cooperation has been outstanding from all participants in the study. The greatest difficulties from an evaluation perspective lie in two areas: obtaining appropriate comparison groups for conducting outcome studies and accessing information from and about clients who are no longer in the program. The courts have all taken almost heroic measures to assist in the evaluation process.

6. Useful data elements to assist in management and monitoring may include, but are not limited to,

☐ The number of defendants screened for program eligibility and the outcome of those initial screenings;

In only one court was the number of defendants screened for program eligibility a readily available statistic. In no instances could we access either the characteristics of persons referred but not accepted into drug court or what alternative form of supervision they may have subsequently been placed in.

☐ The number of persons admitted to the drug court program;

Data is generally available in this category although there is some difficulty with an operational definition of the term "admitted," particularly where persons have failed, been institutionalized and then re-enter this mode of treatment.

☐ Characteristics of program participants, such as age, sex, race/ethnicity, family status, employment status, and educational level, current charges; criminal justice history; AOD treatment of mental health treatment history; medical needs (including detoxification); and nature and severity of AOD problem;

All of these data are usually available somewhere in the treatment complex but it is not uncommon to have to access four or five separate data repositories to develop a client profile as this benchmark suggests. The information is shared on an unstructured basis as issues arise in screening or the course of treatment.

☐ Number and characteristics of participant (e.g., duration of treatment involvement, reason for discharge from the program);

Information is available but not always clear as to its meaning. For instance, in some courts, particularly juvenile drug courts, subjects may be discharged not because they have successfully completed the course of treatment but simply because of client age and time under jurisdiction.

☐ Number of active cases;

All courts keep a roster of "active" cases although the definitions used vary from jurisdiction to jurisdiction.

☐ Patterns of drug use as measured by drug test results;

Testing results are recorded but not in any uniform fashion and frequently these data are not maintained in the court's records but are held by the case manager or treatment provider who conducts the testing.

☐ Aggregate attendance data and general treatment progress measurements;

These data may be available somewhere in the system but there is no systematic recording of such information in most courts. Oral reports are given to the team and the team recorder (usually the drug court coordinator) may make short notes re: compliance/noncompliance, attendance, punctuality, etc.

☐ Number and characteristics of persons who graduate or complete treatment successfully;

Numbers are maintained but comparative profiles of those who have successfully completed the program were not found in any of the fourteen sites.

☐ Number and characteristics of persons who do not graduate or complete the program;

The number terminated is available but not always the reason for such termination, the characteristics of those who did not complete the progam or what happened to them within the judicial system subsequent to their termination.

☐ Number of participants who fail to appear at drug court hearings and number of bench warrants issued for participants;

These data were not regularly compiled by any of the courts studied.

☐ Re-arrests during involvement in the drug court program and type of arrest(s); and

Several courts inticated that they were attempting to maintain records of this information but none of the data systems reviewed contained re-arrest and subsequent criminal history data.

☐ Number, length, and reasons for incarcerations during and subsequent to involvement in the drug court program.

These data are not routinely maintained by drug court personnel.

7. At least six months after exiting a drug court program, comparison groups (listed above) should be examined to determine long-term effects of the program.

Only one of the courts has attempted a systematic approach to examining long-term effects and that effort was not successful because of the non-responsiveness of the former clients. Additional initiatives in this area are being planned and may be more useful as the number of persons completing these progams grows.

8. Drug court evaluations should consider the use of cost-benefit analysis to examine the economic impact of program services

   Although this is a substantial concern to administrators, no formal cost-benefit analyses have been done and there has been considerable opposition to this being undertaken where the comparison group would be more a traditional and entrenched form of alternative to incarceration.

Key Component #9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations

Performance Benchmarks:

1. Key personnel have attained a specific level of basic education, as defined in staff training requirements and in the written operating procedures. The operating procedures should also define requirements for the continuing education of each drug court staff member.

   In all of the courts the personnel meet standard criteria of education and experience for the positions which they occupy. None of the courts specifies training standards as a matter of policy although most, subject to time and resource constraints, actively encourage the staff to engage in continuing education of some form. The opportunities in this regard are somewhat limited.

2. Attendance at education and training sessions by all drug court personnel is essential. Regional and national drug court training provide critical information on innovative developments across the Nation. Sessions are most productive when drug court personnel attend as a group.

   In most instances the original core team attended some type of training and/or visited an operational drug court for orientation. The annual state conference of drug court professionals serves as a major training resource although attendance varies significantly from court to court and by discipline within the teams. There is no systematic form of orientation or ongoing staff development for drug court personnel in this state.

Key Component #10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness

Performance Benchmarks:

1. Representatives from the court, community organizations, law enforcement, corrections, prosecution, defense counsel, supervisory agencies, treatment and rehabilitation providers, educators, health and social service agencies, and the faith community meet regularly to provide guidance and direction to the drug court program

   Eight of the fourteen courts do not have any structure of the type envisioned in this benchmark. Several have some ad hoc groups which are irregularly called on for feedback but these are not as inclusive of community systems as the guideline suggests. Two of the courts have formal advisory structures in place but only one of those appears to be actively involved in offering advice on policy and providing feedback.

2. The drug court plays a pivotal role in forming linkages between community groups and the criminal justice system. The linkages are a conduit of information to the public about the drug court, and conversely, from the community to the court about available community services and local problems.

   Collaboration and coordination among service providers in the AOD area has been a byproduct of the drug court movement in this state. Most of the courts have attempted, with varying degrees of success, to keep the local media informed of drug court activities. Education of special populations like the local bar and law enforcement has been done in several courts but not on any systematic basis. The needs in this area are generally acknowledged but it is a matter of resource priorities and with expanding clientele, limited personnel, and budgetary constraints and pressures, community linkages have been relegated to the "as time permits" category.

3. Participation of public and private agencies, as well as community-based organizations, is formalized through a steering committee. The steering committee aids in the acquisition and distribution of resources..

   Two of the courts list a steering committee. In one the utility became very evident as the study of that site progressed. Critical policy/procedure had eroded over time and as persons in administrative roles changed. Resource acquisition, including the political clout to advocate for this program, has not been a widely shared community responsibility.

4. Drug court programs and services are sensitive to and demonstrate awareness of the populations they serve and the communities in which they operate. Drug courts provide opportunities for community involvement through forums, informational meetings, and other community outreach efforts.

   As noted above, some courts have made an effort to reach special populations such as the Bar or social service coalitions. At the initiation of the program in about half of the communities the judges and coordinators made an effort to explain the program though appearances at civic groups, etc. As time has passed that function has taken a very low priority although attempts are still made to publicize special events such as graduations.

5. The drug court hires a professional staff that reflects the population served, and the drug court provides ongoing cultural competence training.

   In general the staff of drug courts are representative of the population served, probably to a greater extent than other parallel service delivery structures in the locality. This has been a particular concern to treatment providers because of the difficulty in attracting professionally qualified and culturally diverse staff to some of the jurisdictions studied. None of the courts reported that they provided ongoing cultural competence training for the team members.